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ACUTE AND CHRONIC STRESS SYNDROMES (PART II) (PSYCHIATRIC EFFECTS OF EXTREME STRESSES)

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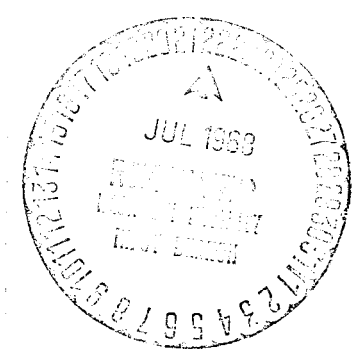

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ACUTE AND CHRONIC STRESS SYNDROMES (PART II)†
(PSYCHIATRIC EFFECTS OF EXTREME STRESSES)

Ulrich Venzlaff††

ABSTRACT. Immediate psychological reaction and later psychotic and psychosomatic effects of confinement in prisoner-of-war camps and concentration camps are discussed in general, without case histories. The relevant German-language and English-language literature is extensively cited and freely quoted. Similar and dissimilar causal factors in the two situations are pointed out and problems of rehabilitation are briefly discussed.

The observations of group disintegration and group structurings cited /369* lead into the depth psychology problems of long-term confinement under extreme conditions. After the first shock due to confinement, capture, weeks of transportation, and confrontation with the horrors of the camp had been overcome, which in many cases took the form of a depersonalization and/or derealization syndrome (J.E. Meyer), within a few weeks usually an apathetic weakening of contact came into play, with increasing dullness and affective leveling, which Bettelheim and Cohen have interpreted as regression to primitive-infantile instinctual attitudes, while Gauger speaks of a "libidinal autism" for the prisoner-of-war situation. In fact we encounter a serious disturbance of the personality in its ego structure here, which has nothing to do with those psychic disturbances which it has been possible to observe in models such as the Minnesota experiment. This is rather a matter of a far-reaching *loss of the libidinal object reference with regression to an oral stage*, which, since of course oral security cannot be attained, is encountered here in excessive distortion, with numerous and sometimes absurd attempts at defense, adaptation, and sublimation. Sexuality quickly subsided; masturbation and pollutions occurred as rarely as sexually colored dreams or homosexual substitute gratifications. Funk reports that even manifestly homosexual prisoners of war felt no urge to gratify their propensities, and also that in a camp of 10,000 prisoners pornographic drawings were found in only one case. Sexual topics of conversation and smutty stories were no longer of interest. In his dreams and daydreams the prisoner spins the cocoon of an infantile experiential environment about/370 him, which he perceives with graphic immediacy. Usually the central figure of the dream world is the mother, experienced as providing protection, care, and nourishment. The figure of the wife undergoes in the dream world of the prisoner of war a romantic idealizing exaltation, in which it is experienced almost

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exclusively as maternally solicitous, sheltering, and protective, with a key, by the way, to explain the numerous marital catastrophes of returned prisoners of war.

In all these phenomena we have to do not with the simple consequences of extinction of the libidino-sexual energies and impulses, but rather with a *transfer of these energies to the oral domain*, which undergoes an exaggerated libidinal cathexis. The constant hunger causes the entire conceptual world to revolve around the intake of nourishment.

All conversations turn upon eating; masochistically, sometimes for hours at a time cooking recipes and reminiscences of opulent repasts are exchanged. There were prisoners who wrote down hundreds of recipes from such conversations and hoarded them like a precious treasure. Frankl reports that inmates of concentration camps coined the word "Magenonanie" ("abdomination") for these conversations, while our prisoners according to their jargon "worked themselves into a heat" (*sich aufgeilten* [the word implies sexual passion]) with these conversations. Schilling has reported that under the influence of such intensive thoughts of food there were orgastic experiences, though without erection and ejaculation, and the pleasure of these experiences was sometimes striven for convulsively. When tobacco was available excessive smoking was indulged in as a consequence of oral frustrations; eccentric ceremonies connected with eating and abstruse customs of spicing were other substitute gratifications.

In not a few cases there were well-marked *symptoms of oral atrophy*, which have already been pointed out. Remembrance of the oral regression phenomena is almost always rejected later by survivors as not belonging to the ego and attempts are made to suppress it. Seemann reports that it was harder to question former prisoners about their eating habits than about their sexual behavior, a circumstance that shows that here a subsequently tabooed complex was being touched upon. In cases where no sublimations were possible in any form, either because of adverse external circumstances or because of lack of inner substance and an already defective super-ego, the imprisonment led to *loss of identity and to existential self-rejection*; egoism, greed, distrust, envy, shameless begging, loss of all concepts of moral values, and unreflecting denunciation gained the upper hand. E. Minkowski once said of the psychic deformation in the concentration camp, "In an affective anesthesia the contact with one's neighbor was lost, the intimacy of life, friendliness, ideology, morality, and systems of values that require respect for death and the dead." Other forms of self-surrender were observed in the form of collaboration with the SS or the prison authorities; camp police and ranking inmates of the barracks or the camp turned into a terroristic clique in whom the libidinal energies, detached from their natural object, became perverted into sadistic excesses and mistreatment of fellow prisoners.

On the other side, there were also sublimations which proved to be effective psychic defense reactions. Where there was a strong and well-established super-ego the world of the camp represented a painful but salutary realization of the worthlessness of many apparent values of the earlier existence; observation of the moral degeneration in the environment could motivate reflection. Members of eleemosynary and healing professions such as clergymen and doctors

at many places bore themselves admirably and were able to promote order and to help by their example and actions. Many prisoners have an almost unbelievable receptivity for metaphysical and religious questions, and, as Kraemer's interviews show, regard this even in retrospect as a human enrichment, but often, too, it was only "praying in need" and was quickly given up after release, -- a self-deceiving regression to an infantile piety.

Frankl on the basis of his concentration camp experience has spoken of "spiritual defiance" and of a "religious progression," and considered these phenomena to be refutation of Freud's view that intense hunger would wipe out every human differentiation and leave instead a uniform manifestation of unsatisfied urges. Again, in interviews with former inmates of Auschwitz recently held at the University of Krakau (R. Lesniak, M. Orwid, A. Szymusik) it was brought out that many former prisoners in concentration camps feel that they experienced not only indescribable horrors, but also a religious and metaphysical deepening.

But such individual experiences must not be overestimated in the face of the severe bodily damage and massive psychic deformations that all survivors of the camps carried away with them, and which represented too heavy an encumbrance for such rapid recovery to be conceivable as was e.g. the rule after release from imprisonment as a prisoner of war under humanitarian conditions. The *psychic and somatic problems of the phases of release and rehabilitation*, with factors that in some cases were also pathogenic, deserve further discussion.

First a brief glance at the somatic aftereffects. Contrary to previous concepts, the *morbus miseriae* required from a year to two years for a complete recovery. There were cases in which intense psychic energies supported the /371 prisoners until the last in the hope of liberation and then fatal collapses came about with the relief from stress. There were sudden deaths among dystrophic prisoners of war during their transport home, and others in the receiving camps in a state of extreme emaciation.

The mortality from liver and kidney diseases, tuberculosis, and cardiovascular complaints was very high among survivors. The vagotonic economizing adjustment of hunger dystrophy was followed in the conversion phase by *painful counteradjustments with sympathetic hyperactivity:* hypertension, pulse acceleration, dizziness, restlessness, and a feeling of pressure. Abnormal metabolic reactions led in the fattening-up phase to a lipophilic tendency with deforming deposits of fat, frequently with gynecomastia in men. For female prisoners the *amenorrhea* which had regularly set in presented a special problem. Except in the case of the older women the cycle came back into play generally within four to eight months, but at first those affected had the depressing feeling of "no longer being a woman," analogous to the effects of the impotence which existed in male survivors for some months. But that this amenorrhea was due not only to functional disturbances, but at least not infrequently to somatic damage to the ovaries is shown by the researches of Klebanow, who observed a shocking incidence of miscarriages, early births, and deformed offspring among women who conceived during the first year after release from concentration camp. Without being able to support this with figures, I share with others the impression that among women with years of camp amenorrhea there is a very high incidence

of sterility, endocrine imbalance, a tendency to cyclic irregularities, dysmenorrhea, cyclic migraine, etc., as aftereffects.

After long-lasting hunger there was always a general asthenia and a lowered capacity in the psychophysical field, a persistent tendency to edema, and a vegetative imbalance. Even when the survivors could return to their accustomed surroundings and found orderly conditions there it took six to eight months before it was possible to return to work, and even then a great many -- deceived by a subjective feeling of well-being -- failed. The attempt of the younger persons to catch up on their school education, university study, or occupational training was often frustrated for a long time by incapacity to study and concentrate.

But with respect to the somatotherapy of concentration-camp damage, conditions on the whole were favorable enough. Although after their liberation the concentration-camp inmates found a chaotic and impoverished Europe, international assistance organizations provided clothing, food, and medical treatment. When the prisoners of war returned to Germany after years of internment, economic conditions had recovered sufficiently that adequate material and somatotherapeutic care was assured. At least in the majority of those affected the physical effects of hunger have worn off in the course of years. At the present time, however, we cannot yet say to what extent damage due to long-lasting hunger may be responsible for premature disability or for a special affinity for cyclic disorders. Studies by Schenk of the causes of death of former prisoners of war and the problem of premature aging due to extreme living conditions suggest reservations concerning the assumption that with clinical cure of the results of dystrophy we no longer need fear permanent damage or later damage to the health.

We now come to a parting of the ways of the two groups of prisoners, in whose fate we have been able to point out so many common factors, especially in regard to the duration and the external circumstances of the sum of stresses and in regard to the primary effects. But it must not be overlooked that from the outstart the inmates of concentration camps, especially the Jews, were in a different original situation, and that the experience of confinement was aggravated by additional factors.

Imprisonment was a dreaded result of participation in military actions, but one that was somehow figured in; it was a normal, logically derived consequence of defeat. Imprisonment in a concentration camp was an infamy innocently and baselessly suffered under the clearly recognizable annihilation plan on the part of the régime, -- a final, inhuman degradation of the individual. The concentration camp inmate was daily confronted with the person of his tormentor, exposed to his will to destroy, profoundly degraded. In spite of the indescribable living conditions under which millions of prisoners of war lived, the dangers there, such as hunger, disease, cold were at least more anonymous. The prisoner of war, too, was confronted with the brutal pressure of prison authority and was exploited to the limit of his capacity for labor, but not in order to destroy him at all costs. As the war progressed, in the concentration camps hope became more and more extinct, and living conditions worsened progressively, so that further survival merely depended on chance. In the prisoner-of-war

camps with increasing length of time after the end of the war the living conditions gradually improved, the terrorism of the prison authorities lost its edge, and after months and years it became possible to send letters and parcels, so that contact with home and family could be reestablished. For the concentration camp inmate there was no "outside" and no "home." Here the families were included in the persecution, and the individual's own distress was added to by worry about the family or despair over separation by selections and the knowledge of their annihilation. In many inmates the lack of relatives or /372
friends for whose sake it was worth while to hold out further weakened the will to resist and the instinct of self-preservation.

Although *the clinical and psychopathological picture of the liberated concentration camp inmate and that of the released prisoner of war* after years of inhuman confinement exhibits far-reaching parallels (extreme emaciation and debility, apathetic resignation, adynamia, poverty of contact due to anxiety and shyness, passive attitudes of defense, loss of differentiation, and primitivization), subsequently this basically different original situation of the experience of confinement manifested itself very impressively in the psychic attitude. We refer here primarily to the anxiety syndrome, which according to Trautmann represents a prominent feature of the psychiatric aftereffects of concentration camp confinement, and which is readily understandable from the peculiar features of the measures of persecution, but also to the far more marked depressive coloring of the psychiatric aftereffects, which is the result of the brutal expulsion from a community, of the all-embracing proscription, the degradation, and the undermining of the self-esteem of these people, who were stamped as "vermin" and made fair game for a criminal clique. This explanation seems compelling to us for the reason that this anxiety-depression syndrome typical of persecution also occurs often in those Jews who -- without being put into a concentration camp -- had to endure proscription and degradation for years under the Third Reich. Moreover, we found especially strong anxiety fixations in those victims of persecution who were able to escape from concentration camp confinement by illegal means but lived for several years under the most dreadful circumstances and under constant anxiety stresses in concealment from their persecutors. Another typical feature of persecution not found among the aftereffects of confinement as a prisoner of war is the *syndrome of "chronic-reactive aggression,"* which K. Hoppe has worked out in a careful analysis and compared with that of *chronic-reactive depression*. While the modification of the personality changes induced by a long stay in camp under extreme conditions with depressive anxiety symptoms is readily understandable from the peculiar features of the Nazi terrorism, the explanation of the stubbornness and *chronicity* of precisely the psychic results of the concentration camp, and also of the remarkably frequently encountered *latent stage* between liberation and the onset of the symptoms, and lastly of the *social descent* found much more often here than among the prisoners of war also requires discussion of the varying conditions of rehabilitation, and specifically of the problems of social therapy and psychotherapy.

German experience in rehabilitation of prisoners of war has shown very plainly the decisive importance to be assigned to social therapy and psychotherapy. The uncommonly long duration of imprisonment had the consequence that these men did not come out like those released from Western custody in 1945 and

1946 into a chaotically destroyed country, but into an economically stabilized country with a powerful industrial potential, in which extensive means existed for help in reintegration into society.

Two central tasks must be accomplished by each one: *reintegration into the family* and *securing a place to live by reestablishment in his occupation.* Under camp conditions the picture of the family had been more and more romantically idealized; it had become in the infantile conceptual world of the prisoner an illusion of the protective group providing security and care and revolving around the fixed pole of a mother figure, while the sometimes brutal reality looked quite different -- in the years of absence of the husbands the wives had had to take the active direction of life in hand, were gainfully employed and emancipated; the children were older and had become strangers, grown up in a different intellectual climate from that of the generation of 20 or 30 years ago; the lack of the commanding father figure in the family could not be changed after the long absence. As in all periods, the loneliness of the women had led to attachments to other men sometimes developing into relationships similar to marriage, and there were tragic cases in which the husband held for years in "silent camps" had been declared dead and a new marriage entered into. The psychically hardened, narrowed, and intolerant men returning home were expectedly less often ready to forgive than in civilian life. Impotence was an additional problem.

The number and extent of the marriage catastrophes among returnees is apparent from the rise in incidence of suicides during the first six to twelve months after return. According to a press report (cited by Wiesenhütter) 20% of the deaths of returnees in Hamburg were charged to suicide. The divorce rate also rose. Statistics also gathered in Hamburg in 1955 and 1956 (cited by Kornhuber) showed divorce soon after return for 12% of those returning, and not only in the case of marriages hastily entered into during the war. Besides these, many marriages were maintained solely for moral reasons or for convenience in spite of the lack of an intimate bond, and the doctor's offices were filled with the wives of returning prisoners of war, who reacted under the stress with a great variety of neurotic disturbances.

For young unmarried returnees there were still other problems in the /373 sphere of intimate human relations. Many who had gone into the service at age 17 or 18, and especially the numerous youths hauled off to Russia in 1945, had regressed much more in their libidinal relationships than the older men, and were physically and sexually immature besides. (There were cases where 25-year-olds still looked like children, but grew up to 10 cm in height within a year after their return.) Psychosexual maturity still had to be achieved late, therefore, a process that often took place under considerable stress. Gerchow has pointed out the frequency of aggressive sex offenses among these persons, and also to a high rate of incest among older, impotent, usually very primitive and therefore libidinally especially disturbed repatriates, observations which are in surprising contrast to Keller's finding of an especially low criminality among returnees. Reintroduction into a supporting community and securing a living space were predominantly a social-therapeutic task, which on the basis of comprehensive legislative acts was extraordinarily successfully accomplished -- finding and guaranteeing employment, assistance in occupational training

(many of those returning home at the age of 30 or 35 had completed no school or occupational training), and gifts of money for subsistence could be made available on a large scale. A feature found to be of decisive psychotherapeutic and social therapeutic importance was the energetic public assistance in the acquisition of dwelling quarters, in the sense of marking out an independent living space, creation of a private domain as a counterbalance to the years of crowding and confinement.

Observation of the results of these rehabilitation measures, insofar as we can survey them at the present time, is instructive with respect to our problem. It was found that the most favorable factors for a complete psychic recovery (of course assuming an adequate physical recovery) were return to an intact family, a fairly young age, intellectual differentiation, completed occupational training and provision of a suitable job, since these factors promoted relationship to objectivity and reality, resumption of social contacts, self-affirmation, pleasure in accomplishment, and social integration, as well as harmonization of the personality and synthesis of the ego. Apart from primarily abnormal personalities, neurotically structured individuals, and the mentally deficient, those who had the worst chances of rehabilitation were the ones who were in captivity an extremely long time (e.g. 10 to 15 years), those who were carried away to Russia as youths and consequently exhibited irremediable defects in their personality maturity, and lastly those who spent that time under especially unfavorable conditions (imprisonment in criminal camps or so-called "silent camps" -- long years of solitary confinement). An especially unfavorable factor in prognosis was the retention of a cerebral defect after extreme hunger dystrophy. The lowered social position was most palpable in these cases. Favorable as the statistical picture apparently was in the incorporation of the returnees into occupational life, it becomes somewhat cloudy when we hear that in a very large part of the cases this was achieved only with a loss in social standing.

Bansi and Peters have reported on a finding that of men who returned in the years 1955 and 1956 only 8% succeeded in rising normally in their occupations, 75% were only tolerably well fitted into their normal occupations, and 17% lost ground more seriously.

In some cases somatic factors may be largely to blame for this -- loss of learning capacity and alertness because of the consequences of hunger, permanent incapacitating physical injury, etc. Surely the principal cause is to be seen, however, in the fact that -- as Kornhuber says -- "by a long exclusion from education, social and professional training, and advance, or by disturbances of his human relationships" a man can be irremediably injured psychically.

The report of these observations suffices to indicate the still more unfavorable situation of concentration camp inmates in the rehabilitation phase.

A great many of them could not or would not return to the countries they came from in Eastern Europe and so spent 2, 3, or 4 years in the psychically poisonous atmosphere of the *displaced persons camps*.

Often the leveling camp situation was not felt as burdensome by the

primitivized survivors, since it gratified their desire for oral security to the extent that it permitted a passive continued vegetation without compulsion to organize one's life and cope with it. But this very factor promoted and fixed the infantile need of protection and the regressive attitude; most of the inmates made no attempt to find work for several years, and the younger ones had no opportunity to catch up on their school education and occupational training; the international aid organizations considered that they were doing what was necessary if they provided decent living quarters, food, clothing, pocket money, and medical treatment, and finally assisted the survivors with preparations for emigration.

On the basis of his experiences in Israel, Levinger took the position that it was not the concentration camp but the DP camp that caused neuroses, a notion that is supported by the indisputable fact that persons who had spent years in DP camps when they immigrated into Israel had nervous breakdowns particularly frequently and exhibited more marked aftereffects of the concentration camp generally, and more especially by the fact that they often reported relative psychic well-being during the period of the DP camp. We are unable to follow these arguments; it seems to us rather that the DP camp, after the /374 removal of the terror, hunger, and other stresses, simply had a protective effect (von Baeyer), which on the one hand fixed the passive security-seeking attitude, but on the other hand was unable to counterbalance the neurotic disturbance. Then, too, during the first years the psychic changes were overlaid with the slowly healing somatic damages, which also dominated subjective experience.

Two other very important factors that we do not encounter in the situation of the prisoners of war are also partly responsible for the persistency of the psychic aftereffects of the concentration camp and for their appearance only after a seemingly quiet *latent period* -- the *inclusion of the family in the persecution*, which we have already mentioned, and *emigration*. The prisoners did not return to an intact family and group structure, but to a community of fellow sufferers who were themselves severely damaged psychically, where assimilation was basically impossible. The relief after liberation and the euphoria of release soon yielded to the shock of the victims at the loss of all or many members of the family. The one who had survived stood alone in a world full of strangers. We are again indebted to Trautmann for pointing out the *"grief syndrome"* of the survivors as a real and existential grief over loss and isolation. But the loss of family members not only explains the motivation of the origin of the grief syndrome as an additional complex of disturbances specific to persecution, but is also of essentially depth-psychological significance, for the *loss of relations* constituted a further obstacle to overcoming the interruption of libidinal contacts through the acquisition of environmental relationships as a part of the reestablishment of the trusted family group. Attempts at compensation with overanxious strivings not filled with harmonious libidinal energies frequently led after liberation to *hastily contracted marriages* between psychically sick and defective partners, which either did not last or turned into constant frustrations with the provocation of symptomatically variegated secondary neuroses. Or else the efforts to build up a new identity and a new objective relationship led to an illusory solution in the form of a permanently egoistic, aggressive attitude as the expression of an oral overcompensation with unin-

hibited, ruthless pursuit of pleasure and possessions. H. Strauss reported grave *characteropathic changes in the young*, which must be blamed on an interaction of oral overcompensation attempts and lack of supporting and guiding relatives.

The loss of all or many close relatives not only manifests itself in the survivors as a grief syndrome, however, but also often led -- as W.G. Niederland has shown us -- to a tormenting *survivor guilt*. "They carry with themselves a double burden of guilt: First, the actual loss, terror and grief experiences through the impact of the disaster and the extermination of their loved ones; second, the ever-present feeling of guilt, accompanied by conscious or unconscious dread of punishment, for having survived the very calamity to which these loved ones succumbed." [Quoted in English. -- Translator]

W.G. Niederland and H. Krystal in 1964 in a depth psychological study ("Clinical Observations on the Survivor Syndrome") pointed out the predominance of masochistic character disturbances in 70% of the persecution victims examined by them and were able to show a significant correlation between masochistic traits and the feeling of survivor guilt (92%). "Of the 115 individuals who lost not one relative in the most immediate family, only 51 (39%) showed masochistic traits." [Quoted in English.] With the loss of the spouse or the children, on the other hand, masochistic traits were found in almost 90% of the cases.

We find in Holland the interesting pointer to a frequent concurrence of the manifestation of nervous breakdowns years after the liberation and the emergence of survivor guilt, when after years of searching and hoping the prospect of seeing the relatives still alive finally fades away. In this circumstance we doubtless have an important factor to explain the *latent phase or symptom-free interval between liberation and the onset of psychic disturbances*, which we encounter in no small number of survivors and which for a long time was difficult to account for.

But another factor of eminent pathogenic significance here is the phase of emigration, which practically all inmates of the DP camps entered into sooner or later. To the removal of the conflict-covering protective effect of the camp was now added transplantation into an unknown life environment alien in speech and nature, in which the regressively narrowed survivors were now suddenly faced with tasks and difficulties and the necessity of actively coping with life. In consequence of this uprooting, to whose significance for the persecuted H. Strauss has called particular attention, depressive and paranoically colored reactions manifested themselves during the very first year after immigration quite as often as organoneurotic conversion symptoms as an expression of repressed aggressions.

In regard to the very complex individual psychological and group dynamic problems and sociological problems of emigration, uprooting, and rerooting we must mention here the works of M. Pfister-Ammende, Murphy, Ödegaard, Pflanz,/375 Eisenstadt, and others, all of which show an increased incidence and rate of morbidity for psychic disturbances in this group of persons, with experience-reactive disturbances specific to uprooting in consequence of difficult or un-

realizable assimilation predominating, but also with a rise in endogenous psychoses as compared to the native population and a premature decompensation of age psychoses.

In a depth-psychological study H. Krystal and Th.A. Petty take the view that "migration initiates a potentially dangerous regressive trend which ultimately perpetuates or revives passive oral desires for the mother of early infancy. These desires tend to be projected into the land of adoption and to predispose the immigrant to experience the inevitable frustations of migration as a repetition of rejection by the mother of infancy." [Quoted in English.] What is indicated here as a potential danger even for "normal" immigration meant for the survivors of concentration camps a specific dynamic frustration, since in his emigration he was transplanted, caught as he was in an oral regressive world of desires and concepts, from a protective situation into a different living environment to which he could construct no reality relationship or only an inadequate one.

On the basis of the observations described we can no longer doubt today that there is a limit to the psychic stress tolerance, which can be exceeded either by years of living under extreme conditions or by too long exclusion from a protective community by terrorization, proscription, and what W. von Baeyer has called the "annihilation of the personality." We see, too, that the somatic effects of extreme living conditions, especially a long-lasting state of hunger with its somatic and psychic effects is capable of raising the psychic effects to a higher power and sometimes lends them a specific coloring. The depth-psychological, group-dynamic, and sociological aspects show, however, that we cannot explain the aftereffects of extreme psychosomatic stresses by a simple cause-and-effect relationship between stress and affected individual. The etiological complications do not become understandable until we get to know the victims of terrorism in their insoluble group-dynamic relationships to the family, the homeland, the protective hereditary environment, and in their sociological order of precedence. Terrorism and the elimination of all systems of values and relationships binding upon man coalesce here with the somatic effects, and we cannot so to speak tabulate the effects of individual factors and arrive at the total clinical picture by addition.

For these reasons any *attempt to classify psychiatric stress syndromes according to their etiology or symptoms* must be prefaced by the restrictive observation that the rich variety of symptoms and the involved etiology will always leave room for reservations. Nevertheless, it appears justified to undertake a classification in which due account is taken of both the etiological factors and the symptoms, and which also considers the various periods of time:

1. The acute stress syndrome as a result of exceeding the psychosomatic stress tolerance through the interaction of somatic weakening, terrorization, and forced collectivization is relatively uniform and is characterized by a *regressive apathy with emotional leveling and primitivization of the personality.*

After removal of the stress this syndrome is wholly or partially reversible, the recovery or transition into the chronic stress syndrome depending first on the extent of the remaining somatic consequences of stress (especially cerebral damage) and the molding force of the psychic influences, and second on the application and result of social therapeutic and psychotherapeutic measures and on sociodynamic factors.

2. The chronic stress syndrome for these reasons is multiform in its symptoms, but exhibits as its *essential symptom* that *change in the life feeling* for which the concept *"experience-conditioned personality transformation"* (Venzlaff) still seems the most fitting characterization: An irreversible discontinuity in the personality with lowered vitality, adynamic-depressive mood, insecurity of human relations (von Baeyer), and the peculiar contrast between the hypermnestic fixation on horrors endured in the past and emotional indifference toward current problems.

The formation and development *of the chronic stress syndrome* is to be blamed on a number of factors that are directly or indirectly connected with the persecution, among which have been mentioned:

a) Original personality and socio-cultural origin partially determine the success of sociotherapeutic and psychotherapeutic measures for assimilation in emigration, and sometimes also the symptomatic differentiation and selection. Von Baeyer, Kisker, and Häfner call attention for example to the fact that a modification with hysterical symptoms is very largely a socio-cultural problem.

b) The time of life in which the persecution was experienced also /376 partially determines the quality and quantity of the symptoms. The greatest psychic stability is shown by persecuted and imprisoned persons in early adult life, the worst deformations by older persons ("collapse of the aged" -- Kolle). Special problems arise with children and youths, who reacted to specific dynamic stresses in childhood most often with psychoneuroses, and beyond the tenth year of age with characteropathic and sociopathic deformations (von Baeyer, Kisker, and Häfner).

c) The specific psychological effect of stress, which is determined by the extent of the terrorization and confrontation with death, the worry, degradation, the duration of the deprivation of freedom, the form of the group of internees and additional stress (solitary confinement, inquisitorial questionings, torture, maltreatment, etc.), is of essential importance for the qualitative and quantitative nature of the symptoms, and especially for the development of the often predominating depressive and anxiety symptoms ("traumatogenic anxiety syndrome" -- Trautmann).

d) The involvement of the family in the persecution and the annihilation of all or many relatives represents an additional pathogenic factor, which often finds its reflection in a modification of the stress syndrome by the grief syndrome described by Trautmann and in "survivor guilt" (Niederland).

e) The rehabilitation situation, lastly, largely determines whether and to what extent there will be recovery, improvement, or fixation of the stress

syndrome; return to an intact family and group structure, quickly applied, effective, and comprehensive sociotherapeutic and psychotherapeutic measures offer the most favorable chances of recovery, while destruction of the original structure, long-term confinement in the camp, long-lasting passivity, and most especially a renewed uprooting by emigration promote the development and chronification of the symptoms ("uprooting syndrome" in H. Strauss's sense). In this connection it must also be borne in mind that the success of rehabilitation is often determined to a very essential degree by the extent of the remaining somatic damage, especially to the central nervous system.

3. Secondary neurotic disturbances, lastly, are to be distinguished from the chronic stress syndrome; they may arise in addition through the presence of a personality change due to inability to cope with the occupational, marital, or emigration situation, and so have at least an indirect connection with the stress suffered.

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